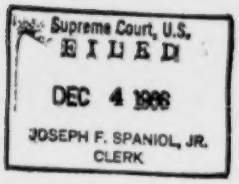

(5)

NO. 86-747

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1986

STEPHEN B. HEINTZ
Commissioner Department of
Income Maintenance
State of Connecticut

Petitioner

v.

DALE HILLBURN,
by his parents and next
friends Ralph and Eleanor Hillburn;

JAMES CORBETT,
by his next friend,
Roberta Reid;

SANDRA FUCHS
by her next friend,
Florence Fuchs

STEPHEN KAPLANKA and MARK KAPLANKA
by their mother and next friend,
Dorothy Napolitano

Respondents

ON PETITION
FOR A WRIT OF CERTIORARI

DAVID C. SHAW
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106

SHELLEY WHITE
Connecticut Civil Liberties Union
32 Grand Street
Hartford, CT 06106

Counsel for Respondents

48pp

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v.

DALE HILLBURN,
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Ralph and Eleanor Hillburn, et al.

Respondents

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

OPINIONS BELOW

The judgment of the Court of Appeals has been reported at 795 F.2d 252.

The opinion of the district court is not reported. The opinion and judgment are reproduced in the appendix to the petition for a Writ of Certiorari at 36A and 77A respectively.

QUESTIONS PRESENTED

1. Whether the State Medicaid Agency is required by federal law to determine through professional medical reviews if nursing homes are providing adaptive wheelchairs to their severely handicapped residents receiving Medicaid where appropriate.

2. Whether the state Medicaid Agency is required by federal law to take effective corrective action whenever a Medicaid recipients' need for an adaptive wheelchair has not been addressed by the nursing home in which he resides.

3. Whether the Commissioner waived his defense that the federal regulations codified at 42 C.F.R. Part 456, Subpart I are unenforceable by Medicaid recipients by not raising it until after trial.

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SUMMARY OF ARGUMENT

Certiorari should be denied because the opinion of the Court of Appeals faithfully follows the legislative and regulatory scheme established by Congress and the United States Department of Health and Human Services that is designed to guarantee that the care and services mandated by Title XIX for nursing home residents are actually delivered. Further, compliance with the lower court's opinion will not interfere with administrative enforcement of the Medicaid requirements since the court mandates only that the state implement regulatory requirements now nearly two decades old.

In amendments to Title XIX in 1968, Congress established three separate, though complementary enforcement mechanisms: (1) state surveys of facilities by state health agencies to ensure that nursing homes meet the conditions of participation; (2) inspection of care reviews to assure that services actually delivered in certified facilities promote their residents' optional functioning; and (3) utilization control. The first mechanism is essentially structural and facility oriented; the other two are patient-oriented and focus on outcomes. This case involves Connecticut's failure to implement the second enforcement mechanism designed explicitly to assure that a skilled nursing facility meets its residents' needs.

The court below was correct in requiring the defendant Commissioner to implement the patient-by-patient inspection of care reviews in accordance with the requirements of the federal statute and regulations. These requirements are clear and unambigous and Connecticut's failure to faithfully implement them has fostered and encouraged inadequate nursing home care for severely handicapped Medicaid recipients.

The court below was also correct that the state agency in charge of Medicaid must follow the federal regulatory requirement to take appropriate corrective action, including termination of a facility's provider contract as a last resort, if the intransigence of certain nursing homes continues. Strong remedial measures are necessary because classmembers have been subjected to severe health risks and even death for over a decade as a result of nursing homes refusal to provide adaptive wheelchairs to persons needing them. As Commissioner of the "single state agency" responsible for implementation of Medicaid in Connecticut, the defendant should have taken strong action before now to address this problem. Individual patient transfers, sanctions against individual nursing home physicians, and individual enforcement actions in state court are a few of

the available but never used enforcement tools which should make termination of provider contracts unnecessary. If, however, a certain nursing home ignores the need of a severely handicapped person for an adaptive wheelchair, termination of the provider contract should be available as a last resort.

The remedial orders approved by the court below are narrowly drawn to eliminate the violations of the legal rights established at trial and do not merit review by this Court. The state is directed to determine only if nursing homes are responding to individual needs for an adaptive wheelchair and to take corrective action when they are not. The Commissioner is not enjoined to take similar actions to enforce classmembers rights to other services under Medicaid such as physical therapy or theraputic feeding. The decision below requires far less of the state Medicaid Agency than the federal regulations themselves and therefore does not mandates impermissibly broad relief.

I. STATEMENT OF THE CASE

This case was filed to obtain adaptive wheelchairs and related services for three hundred of Connecticut's most severely handicapped citizens.[1] Many classmembers are senior citizens, others are retarded, but all reside in skilled nursing facilities (SNFs) and have physical handicaps of such severity that an adaptive wheelchair is necessary to enable them to properly position and align their bodies. Proper body alignment for such persons is necessary to promote safe and proper breathing, swollowing and digestion. Without an adaptive wheelchair such severely handicapped persons are at risk of suffering a deterioration in health and skin breakdown or being subjected to severe injury or death.[2] Hillburn v. Commissioner, Connecticut

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[1] The class was certified on September 19, 1983 to include: All Medicaid recipients residing in or admitted to skilled nursing facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development.

[2] The trial record establishes that the classmembers are exposed to the following risks every day: recurring aspiration pneumonia and hospitalization because classmembers are fed in a supine position; and regurgitation and choking during feeding, reduced range of motion of limbs and progression of physical deformities and regression because of the lack of an adaptive wheelchair, twenty-four hour positioning plan, and physical therapy.

Connecticut Department of Income Maintenance, No. H82-200, slip op. at 11, 14, 15 (D. Conn. July 17, 1985); 47A, 48A.[3]

The named plaintiffs and many members of the plaintiff class were transferred from large state institutions into skilled nursing facilities (SNFs)[4] by the Connecticut Department of Mental Retardation (DMR) in the mid-seventies in order to facilitate the renovation of these facilities to federal Title XIX standards. Hillburn, slip op. at 12; 46A. Under Connecticut law, DMR retains responsibility for the classmembers it has placed and can transfer them to other facilities, but has no authority over nursing homes. Connecticut General Statutes section 19a-451(1). This lawsuit became necessary because DMR and state officials from two other state agencies, each responsible for implementation of some or all of Connecticut's Medicaid plan, ignored obvious needs of the most severely handicapped of Connecticut's nursing home residents for more than a decade.[5]

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[3] References to the appendix to the Petition for a Writ of Certiorari in this case will be made by giving a page reference followed by the letter A.

[4] The term "skilled nursing facility" is defined at 42 U.S.C. section 1395x(j).

[5] The petitioner's assertion that adaptive wheelchairs have been available only in "recent years", petition p. 4, is untrue. The (f.n. cont)

Connecticut participates in the federal-state Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. section 1396-1397f. In accordance with federal Medicaid requirements, see 42 C.F.R. section 431.1 and 431.10, Connecticut has named DIM as the "single state agency" responsible for administering the state Medicaid program. Hillburn, slip op. at 9; 43A. DIM, in turn, has submitted the state's Medicaid plan to the Department of Health and Human Services (HHS). This plan has been approved by HHS. In the plan, DIM, as the state Medicaid agency, promises to carry out the requirements of federal law in exchange for federal reimbursement of fifty percent of all qualifying services delivered under the program. In its capacity as the state Medicaid agency, DIM has entered into written contracts called "provider agreements" with each SNF that participates in the Medicaid program. These contracts are renewed yearly. The provider agreements state that the SNF will provide care and services in conformity with Title XIX, and will meet the conditions of partcipation detailed in HHS regulations

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(f.n. cont.)
district court found that adaptive wheelchairs have been commercially available since 1980. 48A. However, the trial record and the orders of other district courts, See Halderman v. Pennhurst, 446 F. Supp 1295, 1329 (1977), establish that wheelchairs have been individually adapted by qualified therapists for well over a decade.

conditions of participation detailed in HHS regulations. Hillburn, slip op. at 8, 9, 10; 43A, 44A.

In addition to paying for covered medical services to eligible individuals by participating providers, DIM has administrative responsibilities as the state Medicaid agency. These responsibilities include entering into an agreement with Connecticut's State Health Agency, the Connecticut Department of Health Services (DHS), to perform periodic survey and certification inspections of SNFs to determine if they satisfy the conditions of participation in the program prescribed by HHS [42 U.S.C. section 1396 a(a)(33)(A); 42 C.F.R. sections 405.1121 - 405.1137]; to make periodic inspections of SNFs to determine if each Medicaid recipient is receiving appropriate care [42 U.S.C. section 1396 a(a)(31)(B); 42 C.F.R. section 456.609, 456.610, 456.611,]; to take corrective action against noncompliant SNFs [42 C.F.R. section 456.613]; and to issue policy and otherwise supervise the implementation of the state plan in a manner consistent with the objectives of Title XIX. 42 U.S.C. section 1396a(a)(17); 42 C.F.R. section 431.10(e). Hillburn, slip op. at 21-23; 64A, 65A, 66A.

The state stipulated, and the district court found that DIM implements the Medicaid program such that no state agency

determines whether necessary care and services, even medical necessities like adaptive wheelchairs, are actually delivered to classmembers. The state health agency (DHS) determines in the course of its licensing and certification inspections whether each facility has the capacity to deliver adequate care but does not determine whether individual SNF patients are actually receiving necessary medical care or rehabilitative services. Further, DHS takes no action if it is determined in the course of these inspections that a single resident or group of residents are not receiving services mandated by Medicaid. Hillburn, slip op. at 22; 53A.[6] The only other state agency with authority over nursing homes is the defendant DIM. The petitioner stipulated and the district court found, however, that DIM, like DHS, does not look at the services each classmember actually receives during patient reviews. Rather, it looks only at whether the physician orders are being executed. Even if a deficiency is identified in the course of these inspections, DIM takes no

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[6] The district court in Connecticut has agreed with DHS that it is serving its proper role under Medicaid. On March 4, 1982 then Chief United States District Judge T. Emmet Clarie ruled, in a case involving similar issues, C.A.R.C. v. Thorne, No. H78-653 (D. Conn., Consent Decree accepted April 9, 1984), that DHS had "no statutory authority" over the quality of care actually delivered to individual nursing home residents.

action to correct the deficiencies. Hillburn, slip op. at 23; 53A.

The district court judge held that the DIM inspections do not comply with the federal regulations. In particular, he held that the DIM inspections do not determine whether the "services available at the facility" are adequate "to meet [each resident's] current health needs and promote his maximum physical well-being" in apparent violation of 42 U.S.C. section 1396 a(a)(31)(B) and that the reports prepared during these inspections do not contain "observations, conditions and recommendations" concerning "the adequacy, appropriateness and quality of all services provided in the facility... including physician services ..." in violation of 42 C.F.R. section 456.611. He also held that DIM's failure to take effective corrective action based on the patient review team's reports violates 42 C.F.R. section 456.613. Hillburn, slip op. at 41 - 43; 65A, 66A.

On October 8, 1985, the district court entered a judgment ordering DIM to have its patient review teams, in the course of their required inspections, identify persons potentially in need of an adaptive wheelchair and request that the particular SNF involved make, on a case-by-case basis, a professional determination as to whether an adaptive wheelchair should be

provided. The court further enjoined DIM to take corrective action it deems reasonable to ensure that SNFs provide necessary adaptive wheelchairs and "related services".[7] In the event DIM's best efforts fail to remedy a SNF's failure to provide an adaptive wheelchair and related services to classmembers, DIM is enjoined to terminate the SNF's provider agreement with DIM.

The plaintiffs appealed claiming that, having found the defendant DIM in violation of the federal regulations, the district court should have ordered the full implementation of the medical review requirements of the federal law, especially in light of the very great harm the trial record shows classmembers are exposed to from misuse of behavior modifying medications, mechanical restraint, and improper feeding practices. The defendant DIM cross-appealed, arguing that DIM's medical reviews are conducted properly and that the Court orders requiring termination of provider agreements in certain circumstances were improper.

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[7] The term "related services" is narrowly defined on pages 3 and 4 of the Court's judgment to include assessment for an adaptive wheelchair, professional involvement in the design and use of the adaptive wheelchair by the facility staff and a twenty-four hour per day positioning plan. It does not require, for example, that SNFs address classmembers' needs for physical therapy or programs to reduce the inappropriate use of restraint or psychotropic medication. 83A.

The Second Circuit Court of Appeals rejected plaintiffs' appeal for broader relief and agreed with the district court that DIM is not providing the supervision of SNF health care required by federal law. Hillburn v. Maher, 795 F.2d 252 (2nd Cir. 1986). It not only agreed with the district court that the DIM inspection reports failed to comply with 42 C.F.R. 456.611, 795 F.2d at 259, but also that its inspections were in apparent violation of 42 C.F.R. 456.609 entitled "Determinations by Team" and 42 C.F.R. 456.610 entitled "Basis for Determinations". 795 F.2d at 260. Finally, the court upheld the district court's order requiring termination of the provider contracts of irremediably noncompliant facilities as being consistent with the federal regulations, especially 42 C.F.R. section 442.12(d) and the federal regulatory scheme that empowers the single state agency to implement the Medicaid program in a manner consistent with the objectives of Medicaid. 795 F.2d at 261.

II. THE COURT OF APPEALS' HOLDING THAT THE STATE MEDICAID AGENCY MUST DETERMINE THROUGH PROFESSIONAL MEDICAL REVIEWS WHETHER NURSING HOMES ARE PROVIDING ADAPTIVE WHEELCHAIRS TO THEIR SEVERELY HANDICAPPED RESIDENTS RECEIVING MEDICAID WHERE APPROPRIATE IS PLAINLY CONSISTENT WITH THE FEDERAL REGULATORY SCHEME.

The defendant's argument that the federal regulations do not require DIM's patient review teams to evaluate the care each classmember receives is plainly inconsistent with the federal scheme, and does not merit review by this Court. The district

court found that DIM's patient review teams do not assess the appropriateness of the plan of care ordered by a physician. The court below held that such inaction violates the letter and spirit of the federal regulations: 42 C.F.R. 456.609, 42 C.F.R. 456.610 and 42 C.F.R. 456.611.

The statutory basis for the independent professional review requirement is 42 U.S.C. section 1396 a(a)(31). This requirement was enacted as a result of findings by the Senate Subcommittee on Aging, following hearings conducted in 1965, that great variations existed in state nursing home standards, that there was great disparity in the manner and vigor of state enforcement efforts and that nursing home care was, as a general rule, deplorable. Accordingly, Senator Moss proposed new standards as part of the Social Security Amendments of 1967.[8] These new standards require agreements between state health agencies, which license and certify nursing homes and state welfare agencies to facilitate cooperation and communication. The requirement at issue here, medical review, was also introduced through this same legislation. The medical review requirement mandated states to perform a patient-by-patient evaluation of the adequacy of care and services provided and of the necessity for continued

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[8] Public Law 90-248, sections 224 and 234.

placement in the SNF. The Senate Report describes the importance the national legislature attached to independent patient-by-patient reviews:

> The amendment provides, furthermore, for the states to have in operation a professional medical review program under which periodic evaluations of the care provided for Title XIX patients in nursing homes... is made. Such regular independent reviews made by or on behalf of the state agency will provide a mechanism for assuring that patients are receiving appropriate care in an appropriate setting. To the extent possible, it is intended to develop active care designed to enhance the capacity of patients to care for themselves - frequently in a lower cost facility or setting. S. Rep. No. 744; 1967 U.S. Code Cong. and Adm. News 3028, 3029.

State and federal efforts to implement these requirements have been inadequate. In 1970, state inspections of nursing homes were said to demonstrate a "nonchalant indifference" to inadequate care.[9] Statements about the critical importance of independent professional review and the failure of the states to properly conduct these inspections have been voiced repeatedly since 1971 in the national legislature.[10]

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[9] 116 Cong. Rec. H27038 (August 3, 1970)

[10] See Subcomm. On Long Term Care of the Senate Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S. Rep. No 93-1420, 93rd Cong., 2d Session (1974); U.S. Senate Subcomm. on (f.n. cont.)

The federal regulations require DIM to assemble inspection teams composed of appropriate health and social service personnel, 42 C.F.R. 456.602 (b), in sufficient numbers to conduct onsite inspections at intervals determined to be appropriate based on the quality of care being provided and the condition of the recipients. 42 C.F.R. 456.605; 42 C.F.R. 456.606. The teams are required to determine whether the care and services each classmember receives in a SNF are adequate to meet his or her needs based on personal contact with and observation of each recipient and a review of his/her medical record. 42 C.F.R. section 456.608; 42 C.F.R. section 456.609; 42 C.F.R. section 456.610; 42 C.F.R. 456.602. The teams are also required to submit a report to the single state agency (DIM) containing the observations, conclusions and recommendations of the team concerning the adequacy, appropriateness and quality of all services provided to recipients including specific findings about individual recipients. 42 C.F.R. section 456.611. The district court found that, instead of making such detailed

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(f.n. cont.)
Federal Spending Practices and Open Government of the Comm. on Government Affairs, Assuring Quality of Care in Nursing Homes Participating in Medicare and Medicaid 186, 95th Cong., 2nd session (1978); Deficit Reduction Act of 1984, Conf. Rep. No. 861, 98th Cong. 2d session 1362 (1984).

findings and reports, DIM does not even attempt to assess the appropriateness of services. Hillburn, slip op. at 23; 65A.

It is quite clear from the above that DIM has not taken the federal inspection of care requirements seriously. While it is obvious to nonprofessionals that something is seriously wrong when persons with such severe disabilities spend their days lying on the floor in a nursing home without even such basic services as physical therapy and necessary adaptive equipment, DIM inspectors find nothing wrong because nursing home physicians do not order that adaptive wheelchairs or physical therapy be provided. State officials, in response to criticism from families and federal officials, blame each other for this inaction rather than cooperating in the development of a meaningful solution. The federal government has recognized that since SNF physicians may not understand the needs of retarded and severely physically handicapped persons, and has directed, through recent amendments to the state Medicaid Manual, that state reviewing teams determine whether appropriate professional judgments are being made by nursing home physicians. United States Department of Health and Human Services, Health Care Financing Administration State Medicaid Manual, section 4395,

transmittal No. 1, part 4 (October 26, 1982), and transmittal No. 19 (August, 1986).[11] These authoritative interpretations by the federal agency overseeing Medicaid are consistent with the federal scheme and underscore the correctness of the decision of the courts below.

III. THE COURT OF APPEALS' HOLDING THAT THE STATE MEDICAID AGENCY MUST TAKE EFFECTIVE CORRECTIVE ACTION WHENEVER A MEDICAID RECIPIENT'S NEED FOR AN ADAPTIVE WHEELCHAIR HAS NOT BEEN ADDRESSED BY THE SNF IN WHICH HE LIVES IS PLAINLY CONSISTENT WITH THE FEDERAL REGULATORY SCHEME AND THEREFORE NEED NOT BE REVIEWED BY THIS COURT.

The district court found that the state agency responsible for licensing and certifying SNFs participating in the Medicaid program, DHS, does not assess the appropriateness of the plan of care ordered by a resident's physician, and will not cite a SNF for a deficiency affecting only a single resident. Hillburn, slip op. at 22; 53A. The trial court also held that DIM patient review teams, like the DHS teams, do not look behind physician orders, and that DIM takes no action to compel the SNF to correct deficiencies affecting a single resident. Hillburn, slip op. at 23; 53A. The district court found that under this system no

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[11] State Medicaid Manual, section 4395, transmittal No. 1, part 4 (October 26, 1982) is attached to this brief as appendix A (app. A); State Medicaid Manual, section 4395, transmittal No. 19 (August, 1986) is attached as appendix B (app. B) to this brief.

single Connecticut official or agency is accountable for taking action to correct deficiencies affecting a single resident. The district court held that his inaction by DIM violated 42 C.F.R. section 456.613. It enjoined DIM to take "corrective action as needed" whenever medical review teams determining that a SNF had failed to adequately assess the need of Title XIX recipients for an adaptive wheelchair or failed to provide a needed adaptive wheelchair and related services. The court defined "corrective action as needed" to include those steps which the commissioner "deems reasonable" to ensure that skilled nursing facilities provide adaptive wheelchairs and related services to classmembers including, but not limited to, consultation with staff at the SNF, filing complaints with the appropriate medical staff at the SNF, filing complaints with the appropriate medical society and filing complaints with DHS.

DIM argues in its petition that it should be required to take no particular corrective action unless specifically mandated by the federal government. It points out that neither 42 C.F.R. section 456.613 or the Medical Assistance Manual, section 5-60-20 at p. 29 require specific corrective action, especially termination of provider agreements for irremediably noncompliant SNFs. Petition pp. 11,12,14. Connecticut's position on this issue is inconsistent with the Medicaid scheme of having the

program administered and supervised primarily at the state level.[12] Further, the state's protestations of powerlessness are "untenable" in the face of a specific regulatory requirement that the state Medicaid agency take corrective action, 42 C.F.R. 456.613, the terms of provider contracts which require each SNF to provide care and services in conformity with Title XIX, and the fact that under the federal regulatory scheme the state Medicaid agency is ultimately accountable for the implementation of the state plan in a manner consistent with the objectives of Medicaid. Hillburn, slip op. at 42, 43; 65A, 66A. The Court of Appeals affirmed this decision based primarily on the fact that the purpose of the requirement that the state designate a "single state agency" to administer its Medicaid program, see 42 U.S.C. section 1396 a(a)(5); 42 C.F.R. section 431.1 and 431.10 (1985), was to avoid a lack of accountability for appropriate operation of the program. 795 F.2d at 261.

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[12] The Commissioner's argument at page 3 of his petition that nursing homes should now be involved in the resolution of the issues raised by the litigation is suprising for two reasons: First, counsel for the state argued successfully against such participation in the district court and second, counsel for the Connecticut Association of Health Care Facilities, Inc., the law offices of Stephen E. Ronai, in a letter to the district court dated June 8, 1982, informed the Court that neither the association nor any other nursing home he represented wished to represent nursing homes during the trial of this matter.

As the court below notes, DIM's petition ignores the major thrust of the injunction entered against it. The judgment does not require DIM instantly to terminate a provider agreement upon a report of its review team that a SNF is not addressing the adaptive wheelchair needs of a particular resident. Indeed, given the practical and legal obstacles, provider agreements will continue to be rarely, if ever, terminated. Further, there are many options that will secure compliance short of termination which have never been carefully explored by DIM. DIM and DMR have already agreed, for example, to transfer some thirty classmembers from several SNFs to small properly supervised community residences in its court-approved implementation plan in C.A.R.C. v. Thorne, Civ. No. H78-653 (D. Conn., Consent Decree accepted April 9, 1984) because SNFs seem incapable of responding to the individual rules of classmembers. DIM has never vigourously pursued similar actions on behalf of other individual classmembers even though the federal statute and regulations contemplate such actions. See 42 U.S.C. section 1396 a(a)(31)(B); 42 C.F.R. 456.609 (b) and (c).[13] Further, the

[13] The United States Department of Health and Human Services, Health Care Financing Administration has taken the position in recent years that as a general rule, retarded persons should not be placed in nursing homes because such facilities are not equipped to identify or address their habilitative needs. (f.n. cont.)

interpretive guidelines of the federal agency charged with oversight of Medicaid state:

> If a patient is found by the review team to need services not available at the present facility, the single state agency should make arrangements for the provision of these services or transfer to a facility capable of providing them within a reasonable period of time. Medical Assistance Manual section 5-60-20, at 29, transmitted by MSA - PRG - 25 (11/12/72).

DIM may also initiate actions against nursing homes to enforce the provider contracts on behalf of an individual resident, may initiate disciplinary action against nursing home physicians who refuse to order necessary services, and recommend statutory and regulatory change at the state level to ensure that individuals are not lost in the shuffle. None of these actions require disruption of SNF residents who are not classmembers and who may be receiving adequate care. The regulations recognize, however, that DIM may terminate a provider agreement for "good cause" in the unlikely event a particular facility is irremediably

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(f.n. cont.)
has directed states to identify such persons through their inspection of care teams and transfer them to appropriate environments. United States Department of Health and Human Services, Health Care Financing Administration, State Medicaid Manual, section 4395, transmittal No. 1, part 4 (October 26, 1982) app. A, and transmittal No. 19 (August, 1986) app. B.

noncompliant.[14] 42 C.F.R. section 442.12(d). While termination of a provider is an extraordinary remedy, such action should be used when a SNF is indifferent to the health and safety of a particular resident or group of residents. The trial record in this case established that the failure to provide an adaptive wheelchair and related services has indeed created severe health and safety risks. Termination of a facility's provider agreement should be available if consultations with SNFs, patient transfers, and actions in state court or on the administrative level do not result in critical services being provided to classmembers in a reasonable time frame. The Court of Appeals' decision is therefore consistent with the plain language of the federal regulations and does not require review by this court.

Connecticut's argument that the decision of the Second Circuit conflicts with prior decisions of this court is also no basis for review by this court. Indeed, the state admits on page 13 of its petition that the decision of the Second Circuit does

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[14] The petitioner has cited no statute or regulation that is inconsistent with this part of the judgment. Congress intended the independent medical review requirements, 42 U.S.C. section 1396 a (a)(31), and the facility certification requirement, 42 U.S.C. section 1396a(a)(33) to stand side-by-side and to be (f.n. cont.)

not "squarely conflict" with the decisions of this Court or any lower court. O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) and the lower court decisions cited by the petitioner simply do not address the issues raised in the decisions of courts below.

Connecticut's argument that the remedial orders entered by the district court are impermissibly broad also provides no compelling basis for review by this Court. The district court orders do not require sweeping remedial relief. They require only that the state Medicaid agency implement the federal regulatory requirements at 42 C.F.R. part 456, Subpart I and 42 C.F.R. section 442.12(d), to the extent necessary to determine whether SNFs are appropriately identifying each classmember's needs for an adaptive wheelchair and "related services" and are providing such equipment and services when appropriate. The

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(f.n. cont.)
implemented by the states so as to protect each Title XIX recipient's physical well-being. The function of the single state agency requirement is to make these and other Medicaid requirements operate together to improve patient care. The State Medicaid Agency should have the threat of provider agreement termination in its arsenal of remedial tools to secure prompt compliance on behalf of individual classmembers.

judgment does not, for example, require DIM teams to determine whether the services available to each classmember are adequate to promote his maximum potential as is required by 42 C.F.R. section 456.609. It does not, therefore, go so far as to mandate that each classmember's need for physical therapy, theraputic feeding or programming to reduce the use of restraint or psychotropic medications be identified by the DIM teams or that DIM take corrective action where such obvious inadequacies exist. The orders of the district court are, therefore, narrower than plain requirements of the federal regulations. Such limited orders are not impermissibly broad as they require extensive remedial relief less extensive than the violations of rights established at trial and recognized by the Courts below. Milliken v. Bradley, 433 U.S. 267, 280, 281 (1977).

IV. PETITIONER HAS WAIVED HIS CLAIM THAT THE APPLICABLE MEDICAID REGULATIONS ARE UNENFORCEABLE UNDER 42 U.S.C. SECTION 1983.

The Commissioner argues, at pages 15-21 of his petition that the federal regulations set out at 42 C.F.R. Part 456, Subpart I are unenforceable under 42 U.S.C. section 1983. The defendant conceded in his brief to the court of appeals, however, that this argument was first raised in his post trial memorandum. Rule 12(h)(2) of the Federal Rules of Civil Procedure provides that

the defense of failure to state a claim upon which relief may be granted must be raised before the close of trial. Wright and Miller, Federal Practice and Procedure, section 1392 at 862; Simpson v. Alaska State Commission for Human Rights, 608 F.2d. 1171, 1174 (9th cir. 1979). Thus, the defense may not be raised for the first time in a post-trial motion, Black, Sivalls and Bryson v. Shondell, 174 F.2d 587, 591 (8th cir. 1949), or on appeal, Smith v. Atlas Off-Shore Boat Service, Inc., 653 F.2d 1057, 1059, n.1 (5th cir. 1981); Brule v. Southworth, 611 F.2d 406, 409 (1st cir. 1979).[15] Since the defendant has waived this claim it should not be considered by this Court.

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[15] Even if this issue is properly presented, this case need not be reviewed as plaintiffs have a private cause of action under the prior decisions of this Court. Maine v. Thiboutot, 448 U.S.1 (1980); Miller v. Youakim, 440 U.S. 125, 132 n.13 (1979), Quern v. Mandley, 436 U.S. 725, 729 n.3 (1973). The defendant argues, however, relying principally upon O'Bannon v. Town Court Nursing Center, Inc., 447, U.S. 773 (1980), that Medicaid recipients cannot sue under 42 U.S.C. section 1983 to address the deprivation of indirect benefits. This case is, however, clearly distinguishable. First, the defendant Commissioner has known for nearly a decade of the need of plaintiff classmembers for adaptive wheelchairs and related services, yet has failed to take action to implement the mandatory requirements of 42 C.F.R. Part 456, Subpart I. In these circumstances governmental action has encouraged and fostered the SNFs failure to protect the classmembers' health and safety. Governmental action on these facts has directly contributed to the violations of plaintiffs' rights. Second, unlike the risks associated with patient (f.n. cont.)

V. CONCLUSION

For the foregoing reasons this Court should not issue a Writ of Certiorari to the Court of Appeals for the Second Circuit as requested by the State of Connecticut.

(f.n. cont.)
transfers incurred by the O'Bannon plaintiffs, the severe health risks to which these plaintiffs have been subjected were never contemplated by Congress. Third, O'Bannon involved an effort by Medicaid recipients to interfere with proper governmental enforcement of Medicaid. 447 U.S. at 787, 788. This case, on the other hand, involves a failure of state government to exercise its lawful obligation to implement the medical review requirements of the federal law. The plaintiffs have sought and obtained orders that require the Commissioner to begin proper supervision of nursing homes consistent with the Medicaid requirements. These orders do not interfere with proper enforcement efforts - they only mandate that the federal requirements be honored.

Respectfully submitted,

David C. Shaw
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106
(203) 249-9321

APPENDIX A:

STATE MEDICAID MANUAL
Section 4395, Transmittal No. 1
Part 4 (October 26, 1982)

STATE MEDICAID MANUAL
PART 4 - SERVICES

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 1 Date October 1982

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Table of Contents	4-1 (1 p)	———
Section 4395	4-1 (1 p)	———

This is the first issuance in Part 4 of the State Medicaid Manual.

NEW POLICY--EFFECTIVE DATE: October 26, 1982

Section 4395, Inappropriate Placement of Mentally Retarded Persons in SNFs and ICFs.--This section emphasizes the need for appropriate placement of mentally retarded persons in SNFs and ICFs to satisfy their developmental needs.

4395 INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that many retarded persons in general care facilities are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When inappropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsiblity on the facilities, inspection of care teams, and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement required to satisfy the developmental needs of mentally retarded individuals in SNFs and ICFs. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should ideally be certified for ICF/MR care. If the primary need for care is medical, then the person may appropriately be placed in a SNF or ICF.

It should be stressed that even when the primary needs of retarded persons in SNFs or ICFs are medical, their developmental needs must still be met by the facility in the context of the individual's overall physical condition. 42 C.F.R. 442.306 specifies that an ICF must insure admission of only those individuals whose needs can be met by the ICF itself, by the ICF in cooperation with community resources, or by the ICF in

cooperation with other providers of care. 42 C.F.R. 456.609 indicates that the inspection of care team must determine whether the services available in the facility are adequate to meet the health, rehabilitative, and social needs of each resident and to promote his/her maximum physical, mental, and psychosocial functioning. If a facility is not able to provide the services either directly or under an arrangement with an outside source, mentally retarded individuals in need of such care should not be admitted to the facility.

APPENDIX B:

STATE MEDICAID MANUAL
Section 4395, Transmittal No. 19
Part 4 (August, 1986)

STATE MEDICAID MANUAL
PART 4 - SERVICES

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 19 Date August 1986

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Sec. 4395	4pp.	4pp.

CLARIFICATION - EFFECTIVE DATE: Not Applicable

Section 4395, Inappropriate Placement of Mentally Retarded Persons....
This section is expanded to include more specific guidance for evaluating the appropriateness of nursing home placement of retarded persons....

4395. INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs.

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that as a result of inappropriate placement many retarded persons in general care facilitites are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When appropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsiblity on the facilities, inspection of care teams and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement to satisfy the developmental needs of mentally retarded individuals. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. Chronically handicapped persons who are stable but who have severe disabilities have sometimes been placed in nursing homes not because their conditions preclude them from living in another environment but because continued coverage under Medicaid is sought.

Only a small percentage of mentally retarded persons would appropriately be placed in SNFs. This group would include these individuals whose physical condition requires skilled medical care on an inpatient basis that cannot be provided in an ICF/MR or other type of facility or home. It should be stressed that even when the primary needs of retarded persons in SNFs are

medical, their developmental need must still be met by the facility to the extent allowed by the individual's overall physical condition. In most cases, however, if their medical needs are so great that SNF care is required, the patients will not generally be well enough to receive a typical program of a wide spectrum of developmental training, especially if it is provided outside the facility. In such cases, the facility must still aggressively pursue those areas of intervention needed, (e.g. sensory stimulation, range of motion, toilet training as possible). A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropirate setting. 42 CFR 456.609 indicates that the inspection of care team must determine whether the services available in the facility promote the patient's maximum physical, mental and psychosocial functioning. If retarded residents are not receiving the care described above, this requirement would result in a negative inspection of care finding. Continued general acceptance of the inappropriate placement of retarded persons in nursing homes is unacceptable.

Another small group that may appropriatley be placed in a general care facility would include those mentally retarded persons of advanced age for whom developmental training is no longer appropriate. These persons may appropriately be placed at an ICF if institutional care is required. This decision must be made on an individual basis rather than at an arbitrary age because some elderly retarded persons receive benefits from continued developmental services.

Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement. Utilization Review is a State plan requirement and disallowance of payment may be made to correct this problem; inappropriate placement may also jeopardize the "approved" status of a State plan. Section 2363 of the Deficit Reduction Act of 1984 (Public Law 98-369) has altered the requirements relating to UC penalties and has made some items previously subject to UC penalties (i.e. certification and recertification of the need for care, plan of care, and utilization review) State plan requirements not subject to the penalties. However, these requirements may still be the subject of disallowances. Utilization Control penalties are also still in place under the inspection of Care provision and such penalties may be imposed where findings of inappropriate placements have been cited and not corrected.

NO. 86-747

In the Supreme Court of the
United States

October Term, 1986

STEPHEN B. HEINTZ, COMMISSIONER,
CONNECTICUT DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner

v.

DALE HILLBURN, by his parents and
next friends, Ralph and Eleanor
Hillburn, et al,

Respondents

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

CERTIFICATE OF SERVICE

Attorney David C. Shaw, Counsel of Record for Dale Hillburn et al, and a member of the Bar of the Supreme Court of the United States, hereby certifies that on this 4th day of December, 1986, copies of Respondents' Brief in Opposition to Petition for a Writ of Certiorari were mailed, first-class, postage prepaid, to: Hugh Barber, Esq., Assistant Attorney General, 90 Brainard Road,

Hartford, Ct 06114, Attorney Shelley White, Connecticut Civil Liberties Union, 32 Grand Street, Hartford, CT 06107; Janey Bell, Esq., Legal Aid Society, 525 Main Street, Hartford, CT 06103; and R. Jeffrey Sands, Esq., Wiggin & Dana, Esqs., 195 Church Street, New Haven, CT 06510, Stephen Ronai, Esq., Murtha, Cullina, Richter and Pinney, CityPlace, Hartford, CT 06106.

I hereby certify that all parties required to be served have been served.

David C. Shaw
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106
(203) 249-9321